

Practitioner Utilization

2002-2003

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What's to Come

- Goals
- Data and methods
- Volume, spending, and payment rates
- Selected policy topics
- Conclusions

Goals

- Measure use of practitioner services for under-age-65, privately-insured MD residents
- Examine trends
 - Volume of care, payments
 - Fee level (price per service)
- Examine areas of policy interest

Data and Methods

- Maryland Medical Care Database (MCDB)
- Practitioner services only (mainly physicians)
- Quantity measure is Medicare relative value unit (RVU) scale – allows for comparison by a standardized unit of care.
- Payment is sum of insurer and out-of-pocket portions
- Caveats
 - Claims data imprecise, (e.g., some persons, services excluded)
 - Changes over time reflect shifts in enrollment (e.g., increasing HMO enrollment)
 - Less HMO capitation means more care is reported from HMOs, but capitated primary care is not reported.
 - Carefirst's HMO (BlueChoice) is FFS only
 - Other HMOs increasing use of FFS

Summary of Prior Reports

- Data from 1999 – 2002
 - Maryland fees averaged near Medicare level
 - Stable practitioner rates from 1999-2001, 2 percent increase in 2002
 - Quantity of care (total RVUs) grew about 10-12% per year
 - Utilization per user and increase in users were factors in volume growth
 - Highest growth in imaging, hospital outpatient department (OPD)
 - Significant variation in fees relative to Medicare by type of service and by region of the state.

Increases in Volume of Care and Payment, 2002-2003

Growth in Volume of Practitioner Services, 2002-2003

- Total spending or volume increase
 - Non-HMO: 2% increase in spending
 - HMO: 17% increase in FFS spending and 11% increase in (RVUs)
 - Total spending increase was about 6%
- Recall caveats above
 - Shift of enrollment to HMO
 - Reduction in capitation boosts HMO FFS and measurable reimbursement

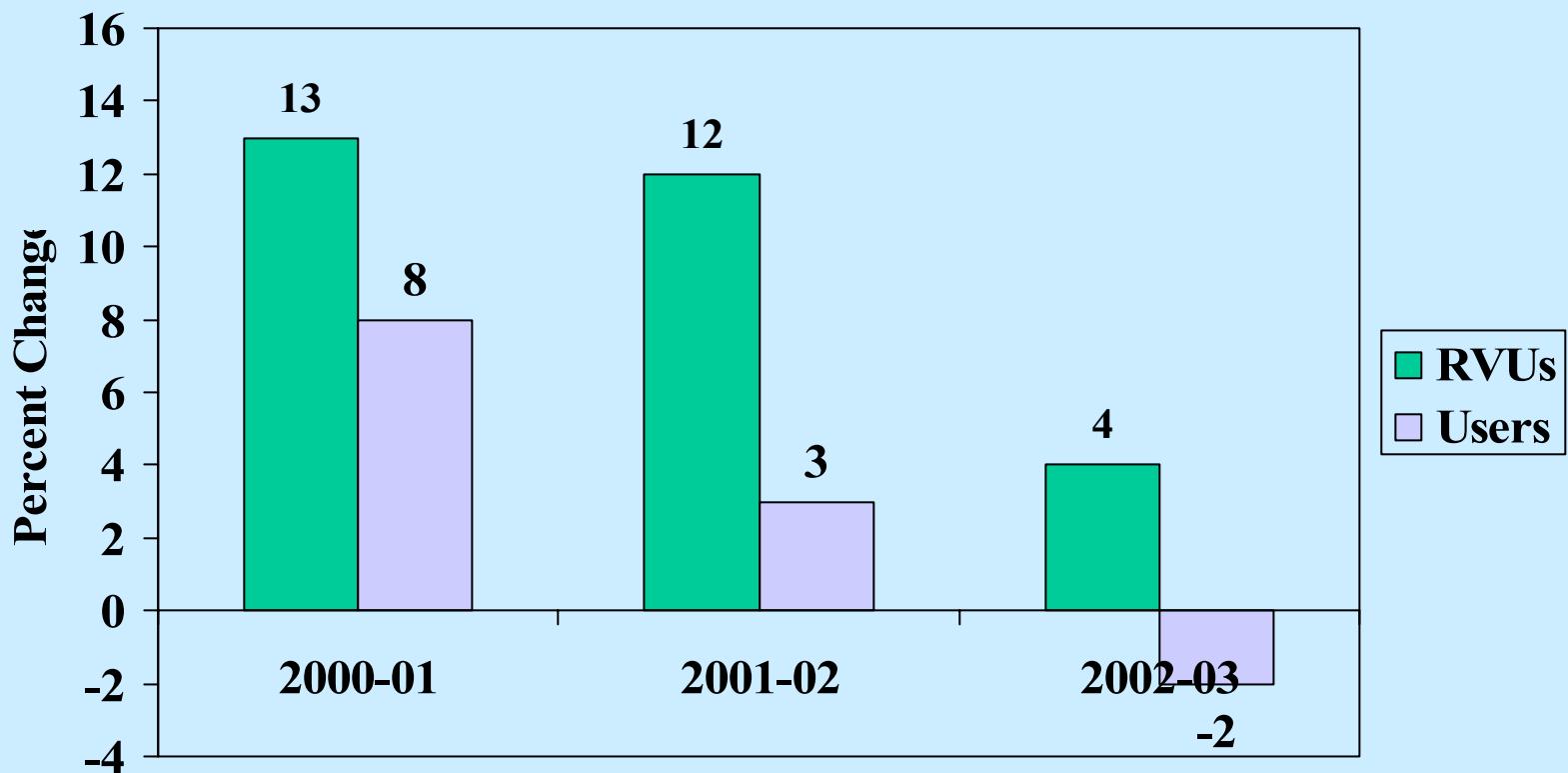
Spending Increase 2002-2003

SOURCES OF SPENDING GROWTH	TOTAL	NON-HMO	HMO-FFS
Increase in Payment Rates	2%	1%	3%
Increase in Reported Persons Using Services	-2	-5	5
Increase in Services per Reported User	3	4	3
Increase in Intensity per Service	3	2	6
Total Spending Increase	6%	2%	17%

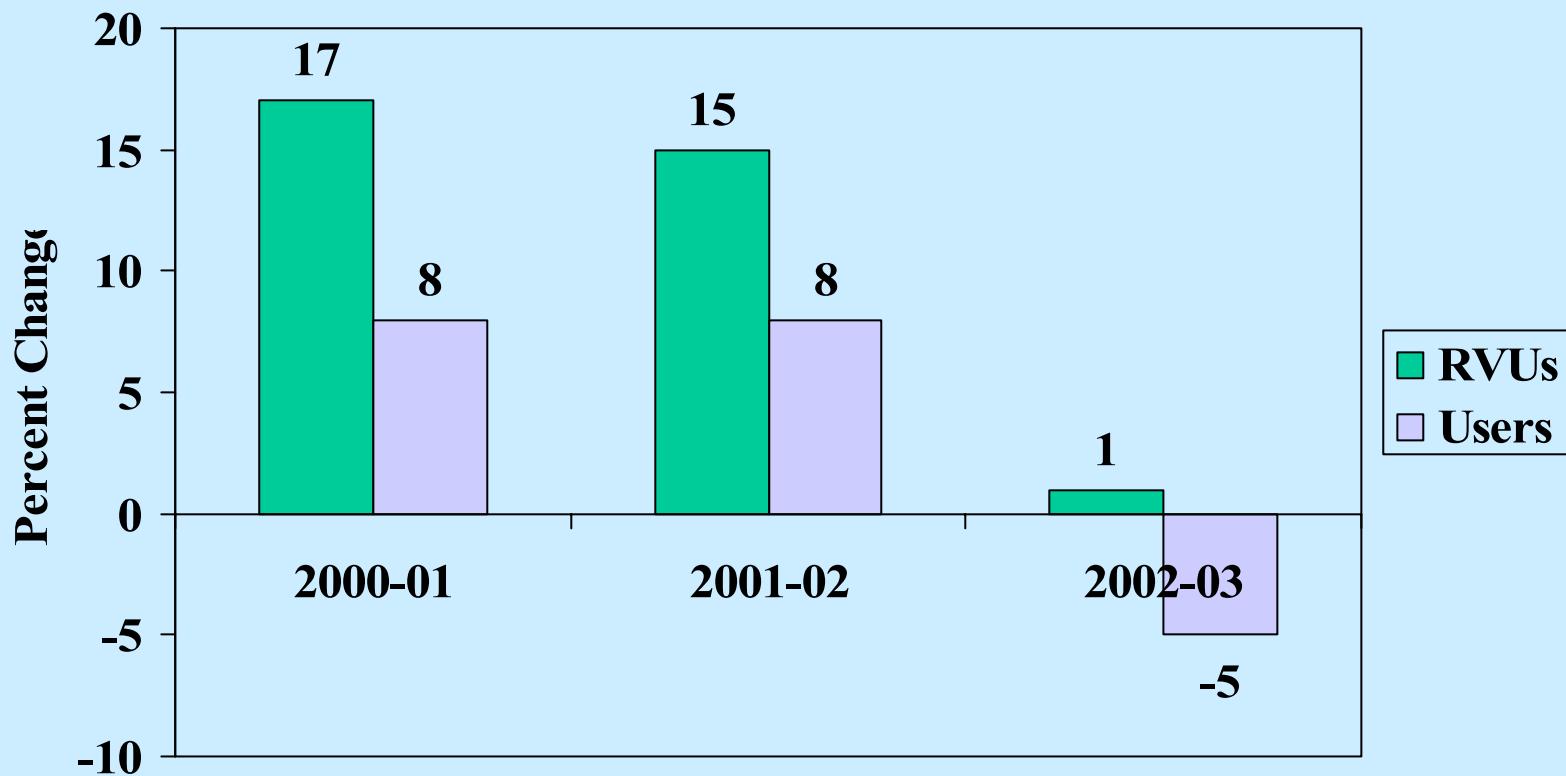
Note: HMO enrollment grew by 5 percent 2002-2003.

Slowing Growth Trend, All Plans in 2002-2003

(HMOs + non-HMOs)

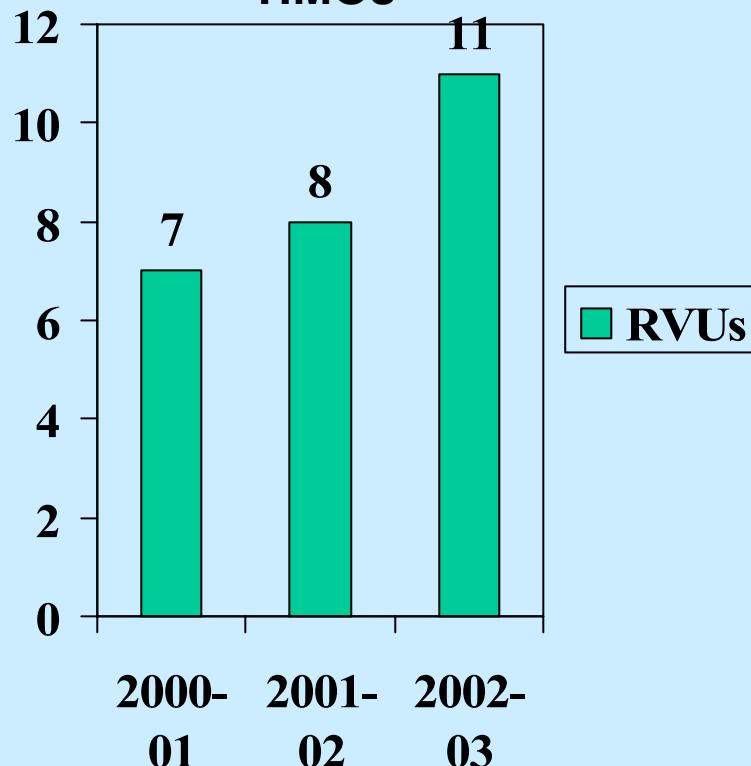


Dramatic Slowing for non-HMOs, 2002-2003

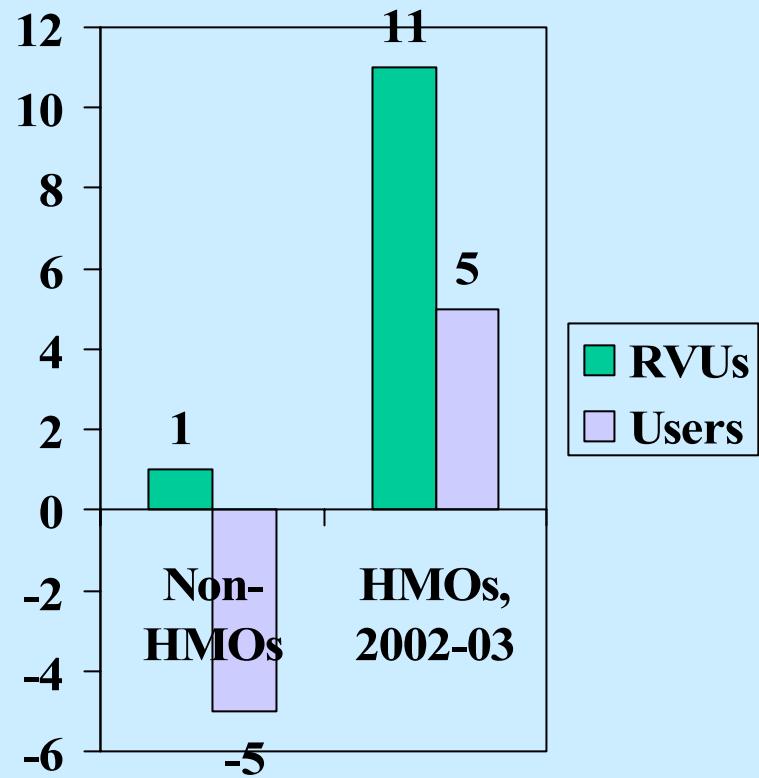


HMO Service Volume (RVUs) Increase Preceded the 2003 Enrollment Jump

Growth in RVUs for
HMOs



Growth in RVUs and Users –2002-2003



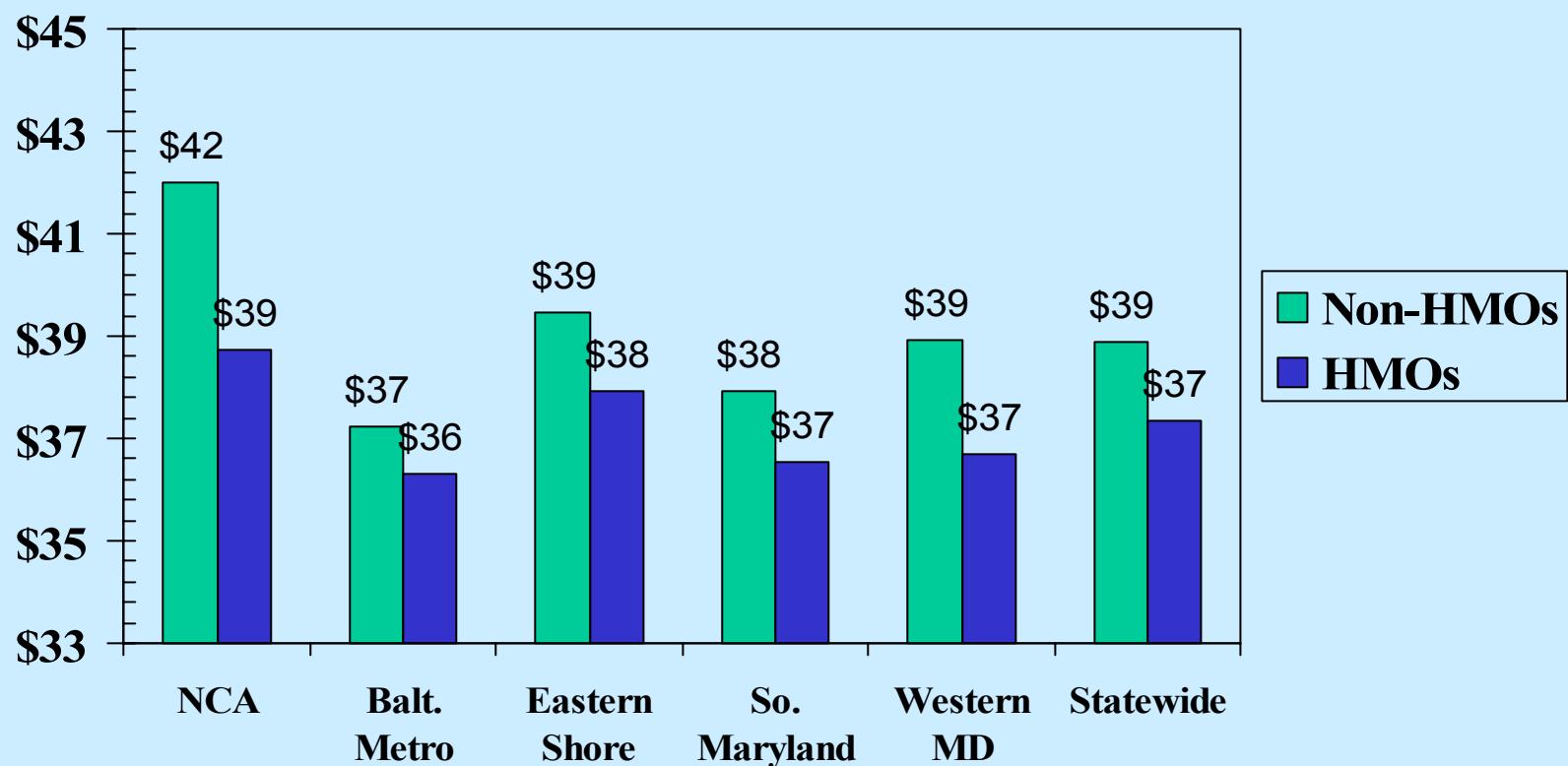
Payment Rates of Private Plans and Comparisons with Medicare Rates

Payment Rates: Methods

- Claims data only
 - Non-HMO + HMO fee-for-service data
- Cross-sectional analysis, 2003
 - Calculate private payment per RVU
- Trends, 1999-2003
 - Calculated without reference to RVUs
 - Analyses focus on non-HMO sector because the scope of services is complete

Cross-Sectional Analysis

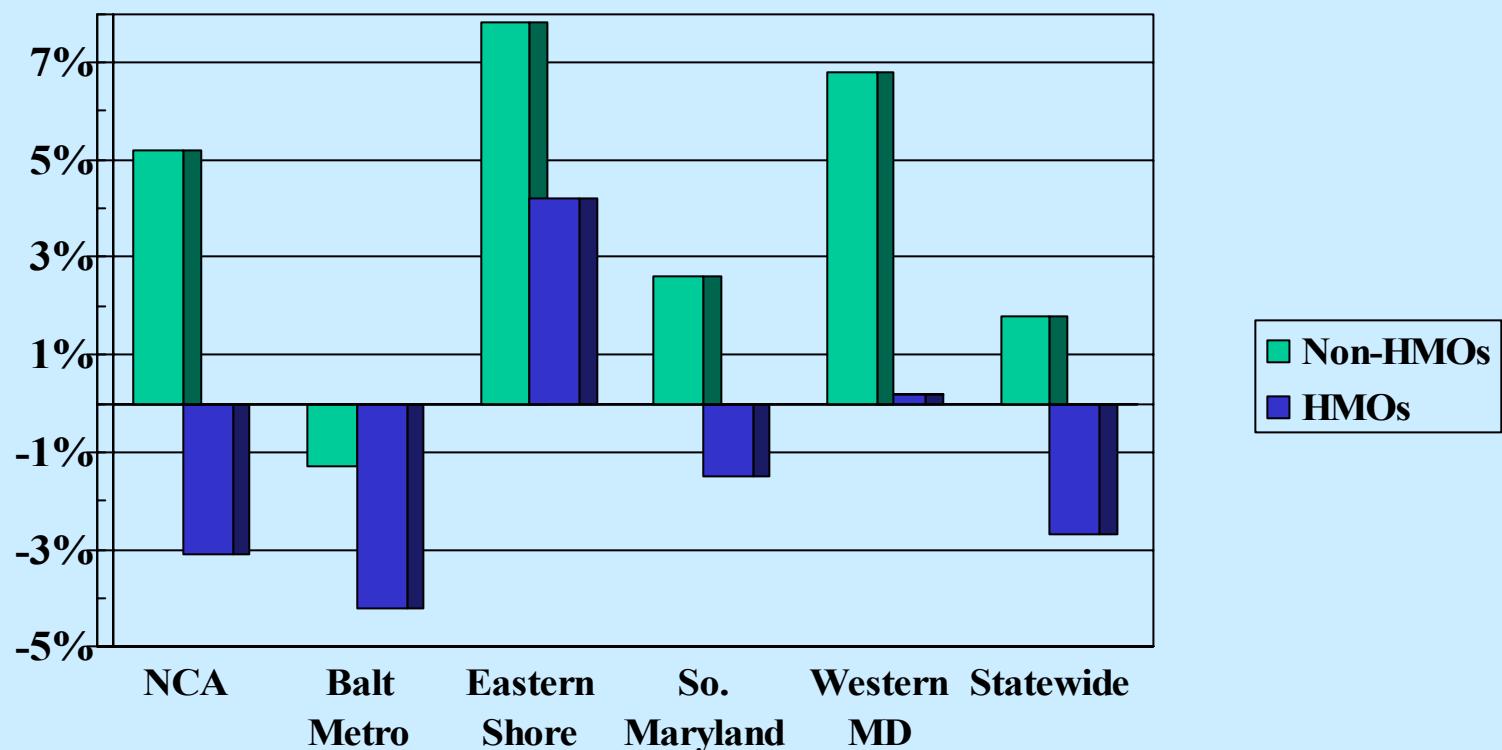
Payment per RVU Varies Across Maryland Regions



Maryland Private Fee Levels

- Maryland fees are below national average
 - In the aggregate, the average private non-HMO price is 2% above Medicare, and the average HMO-FFS price is 3% below Medicare
 - In the U.S., the average private fee is about 123% of Medicare
- Maryland probably continues to be in bottom one-quarter of states in terms of private fees relative to Medicare.

Private Fees Relative to Medicare Varies by Region (percent difference relative to Medicare)



Policy Topics

1. Alternatives for Paying Non-Participating Physicians
2. Are Patient Co-payments in CSHBP comparable to Other Products?
3. What is the Level of Reimbursement for High-Risk Procedure?

HMO Payment to Non-Contracting (Non-Participating) Providers

- Current law sets minimum payment rates
- Apparent compliance with statutory minimum payment rates was unchanged during 2000-2002, full compliance could increase payments by no more than 9%.
- Some practitioner groups interested in a more transparent minimum floor.

How Non-Participating Payment Rates compare to Medicare fees? (Payment/RVU)

		Percent services where payment exceeds...		
	% of non-par services	Medicare	120% of Medicare	150% of Medicare
ER Visits	20%	99%	64%	43%
Office Visits	12%	59%	41%	18%
Minor Procedures	4%	65%	54%	45%
All	100%	78%	53%	34%

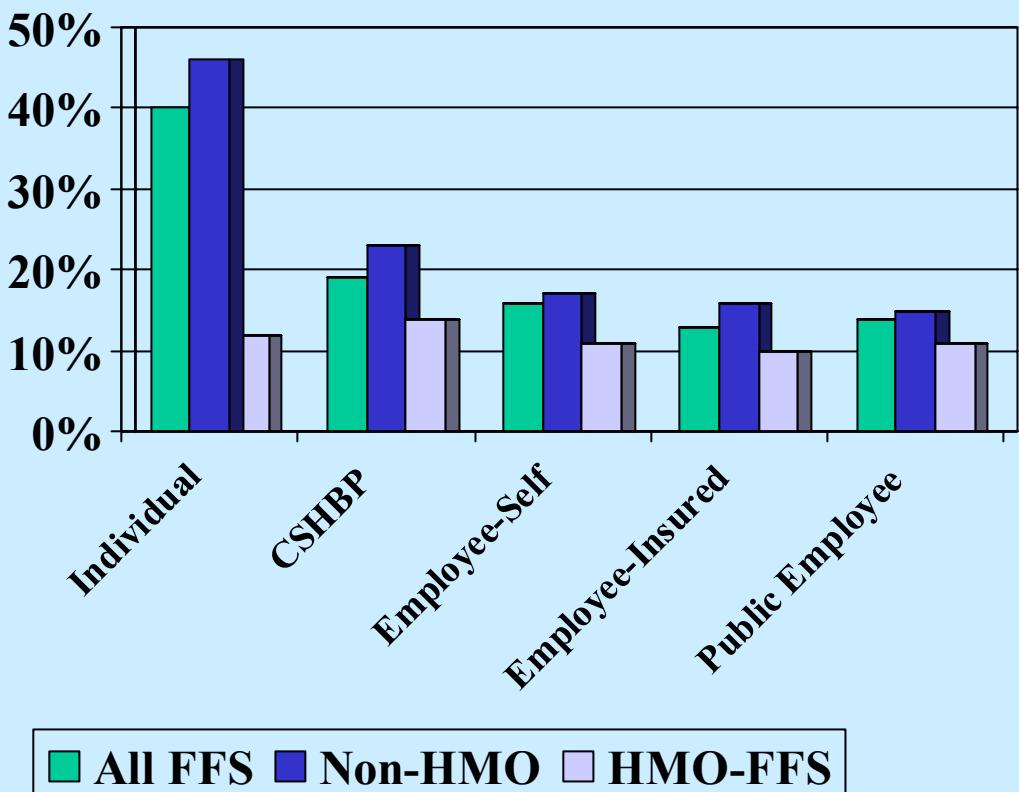
Comparing Patient Co-payments in CSHBP with Other Products

- CSHBP provides standard benefit to employers in small group and self-employed
- Standard plan has relatively high deductibles, many employers buy riders to “buy down” co-insurance and deductible.
- MHCC regulates benefit structure for statutory “affordability” cap: Premium cannot exceed 10% of average wage.
- Level of patient co-payment is a useful monitoring measure. How does CSHBP compare to other plans?

Out-of-Pocket Costs in CSHBP Products Fall Between Group and Individual Purchase Plans

(Share of Practitioner Payments Paid Out-of-Pocket, by Product Type)

- Patient out-of-pocket shares are virtually unchanged from 2002. CSHBP overall share was 20% in 2002 versus 19% in 2003. Patient share in HMOs was 19% and in non-HMOs was 23%.

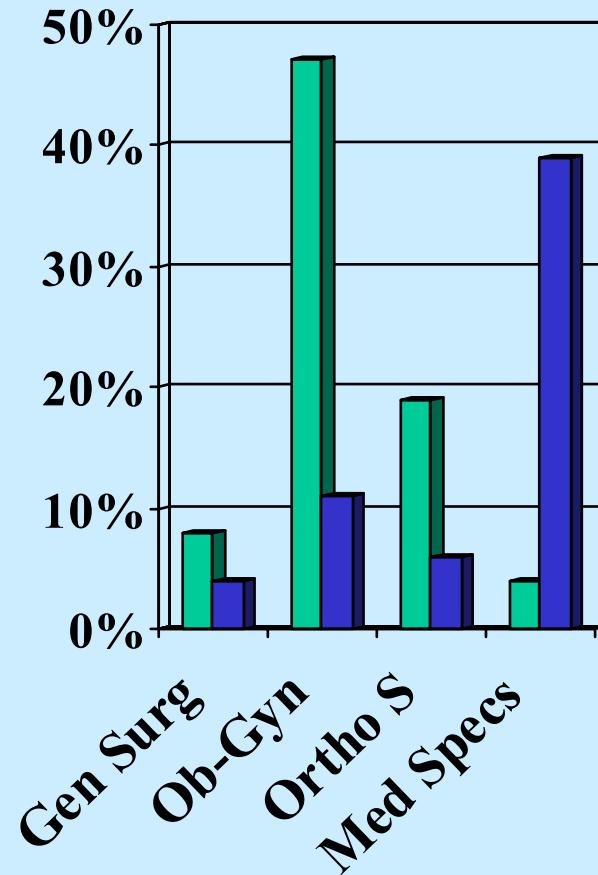


Payment for High-Risk Services

- Considerable interest state- (and nation-) wide in increasing malpractice premiums and implications on access to care
- MCDB used to examine payments for services that underlie premium classification
- *High-risk* services/procedures (HR) defined as those with
 - malpractice percent $\geq 6\%$
 - total RVUs > 1.0 (Number of Procedures=811)
- Compared payments for HR and average services/procedures
 - 93% of payments for (HR) are for “procedures,” versus 25% for all physician care

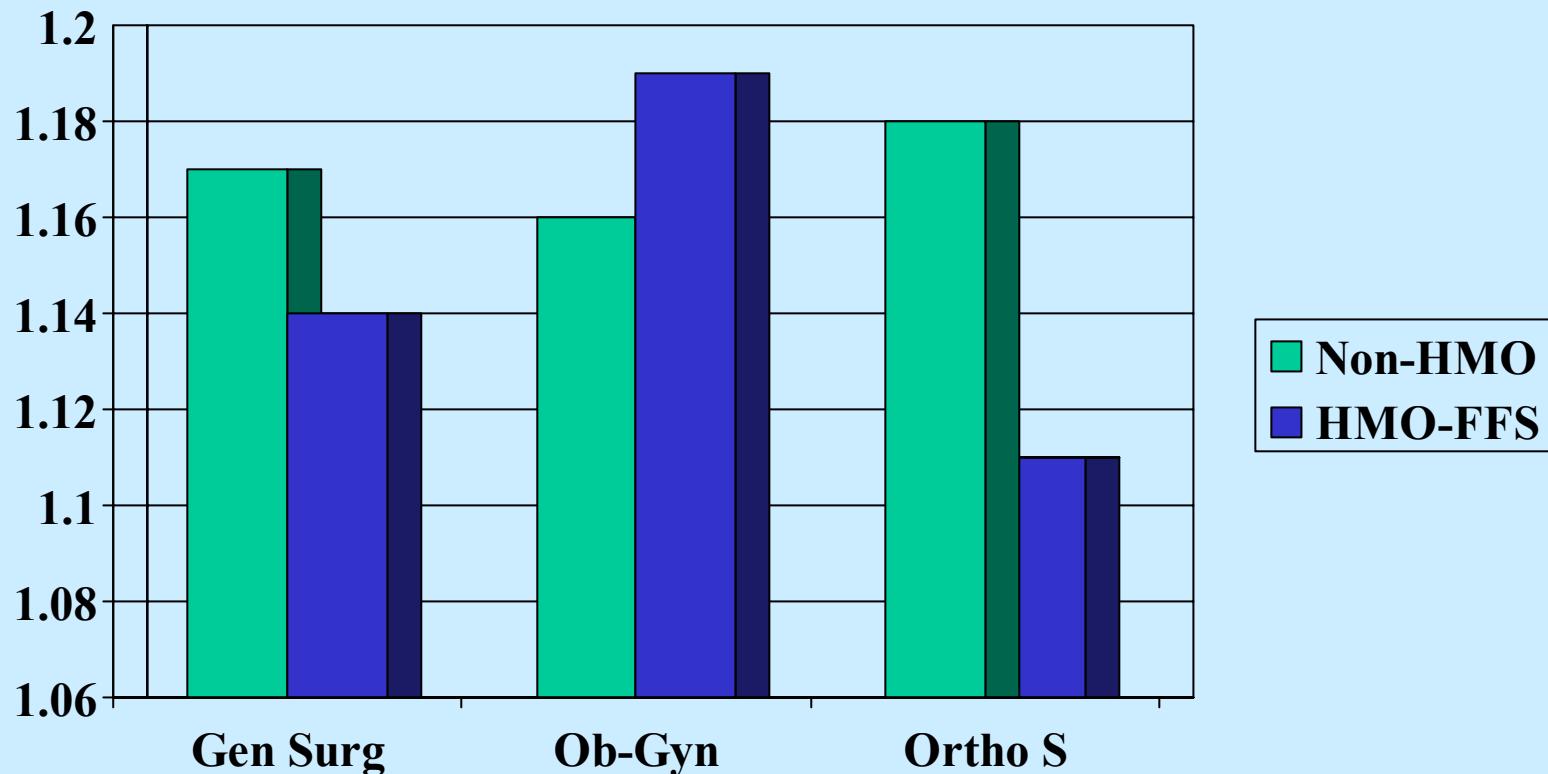
High-Risk and All Service Payment Shares Vary by Specialty

- OB-GYN accounts for about 11% of all payments, but 47% of high-risk payments.
- Medical specialties account for 39% of all payments, but only 4% of high risk procedure payments.



High Risk Payments Exceed Average Payment by 11 to 18 Percent

(ratio of payment per RVU for HR vs. all services, all plans)



Full Impact of Payment Difference Cannot be Known with Certainty.

- Whether revenue covers the higher malpractice premium depends on several factors...
 - Volume of service performed
 - Payer mix – high private payer share will likely mean practice is better off
 - Other practice costs
 - Physician supply in a market
- Financial position of HR specialists eroding with double-digit malpractice premium increases...
 - Even when rates increase, total volume may not. Total payments OB-GYN grew by less than 1 percent in 2003.
 - Rates under Medicaid are even lower
- Until recently attention was on low fees for evaluation and management services

Use and Diffusion of Imaging Procedures

- MCDB reveal that share of payments for types of imaging and their sophistication do not vary by plan type
- Imaging procedures (all types) are used more frequently under non-HMOs than under HMOs
- Over time,
 - diffusion – measured in terms of procedures per user – has been most rapid under HMOs --
 - price (payment per RVU) declined during 2000-2003 for all types of imaging, under all plans – possible payer response to high volume growth.

Conclusions

- Growth in payments was driven by volume and intensity increases. The number of privately insured users - trending downward.
- Modest fee increase first reported in 2002 continued in 2003. Overall fees are about 4 percent higher than 1999.
- Maryland fees are relatively low (about 25th percentile of states), plausibly due to high physician supply and managed-care penetration. Little evidence to suggest they have changed from 2002.
- Difference between HMO and non-HMO average payments is small. Gap is widest in National Capital Area. Baltimore has low average rates, due perhaps to market concentration and abundant supply.

Conclusions (continued)

- 125% of Medicare appears to be a more transparent standard, but payments for some surgical procedures could fall and costs to payers could increase
- CSHBP out-of-pocket share of costs are above, but relatively close to, shares calculated for other group products.
- High-risk procedures are typically paid from 11 to 18 percent above payers' average payment rates. Higher rates represents historical preferences rather than payer response to malpractice crisis.
- Growth in diagnostic imaging continued in 2003. Payment rates for these services fell, but total spending continues to grow.